Bureau of Insurance

A Report to the Joint Standing Committee on Banking and Insurance of the 120th Maine Legislature

Review and Evaluation of
LD 600, an Act to Implement the Recommendations of the Joint Select Committee on School-based Health Care

January 8, 2002

Table of Contents

I. Executive Summary

The Joint Standing Committee on Banking and Insurance of the 120th Maine Legislature directed the Bureau of Insurance to review LD 600, an Act to Implement the Recommendations of the Joint Select Committee on School-based Health Care. The review was conducted using the requirements stipulated under 24-A M.R.S.A., §2752 as amended by Public Law 2001, Chapter 28. This review was a collaborative effort of MMC Enterprise Risk Consulting, Inc. (MMC), a global professional services firm and the Maine Bureau of Insurance (the Bureau).

LD 600 would amend sections of Maine Law pertaining to Medicaid, individual health plans, group health plans and HMOs. This study focuses only on the provisions in the bill mandating that health carriers cover services provided in school-based health centers. These provisions would require:

- Health carriers to provide coverage for services provided in school-based health centers if the services would be covered under the policy in another setting; and
- Managed care plans to provide coverage for services provided in school-based health centers without requiring prior approval from a primary care provider; however, school-based health centers would be required to notify the primary care provider within three business days after the services are provided.

The bill contains the following additional requirements, which are beyond the scope of this report:

- It would require the Department of Human Services to provide the state match for federal revenues under the Medicaid program for services provided in school-based health centers;
- It would require the Department of Human Services to adopt rules allowing school-based health centers to become eligible for reimbursement for case management services to Medicaid-eligible children; and
- It would require the Department of Human Services, Bureau of Health, Division of Community and Family Health to convene an advisory group to develop standards and guidelines for school-based health centers and a certification process for school-based health centers. The advisory group would be required to submit its report and any necessary implementing legislation to the Joint Standing Committee

on Health and Human Services.

In Maine, the first school-based health centers opened in 1987. By 2000, 13 of Maine's 285 school districts had one or more school-based health center. The total number of centers was 20. Six more opened in the fall of 2001. School-based health centers are distributed throughout Maine in both rural and urban areas. Based on the number of existing centers, the mandate would affect 2.15% of Maine's students.

Current insurance law does not mandate coverage of services provided by school-based health centers. However, fee-for-service plans can and sometimes do reimburse school-based health centers. Managed care plans reimburse school-based health centers if the centers are sponsored by hospitals or rural health centers that have a contract with the managed care plan. This bill as written does not require the centers to participate but during the public hearing, proponents indicated that they would be willing to meet participating provider requirements.

No other states have passed laws mandating insurance reimbursement for school-based health centers. The focus of states' efforts and studies have been in the area of Medicaid reimbursement and organizational issues rather than insurance reimbursement.

The services provided by school-based health centers are more extensive than those provided by a school nurse. Also, the types of providers found in school-based health centers include physicians and mental health professionals. Currently there are 26 school-based health centers in Maine, six of which opened in the fall of 2001. A recent survey conducted by the School Based Health Council of the 20 centers operating in Maine in 2000 indicated that, on average, 25% of the students at the school used the center. Services provided included preventive health visits, health counseling, health risk screenings, reproductive health care, and chronic physical and mental health condition monitoring. Chronic physical health conditions include asthma, obesity, diabetes, allergies and ADHD (Attention-Deficit/Hyperactivity Disorder). Chronic mental health conditions include depression, anxiety, substance abuse, and adolescent adjustment disorder.

Having services available through schools increases access to health services. Students have transportation to their schools and do not have to depend on others for transportation as they may have to do in order to access health services in other settings. Taking children to the doctor can be a problem for parents who work during the day, who have other children to care for, or who do not have transportation available.

The requirement of LD 600 to report services to PCPs may inhibit some students from using services that they would prefer to keep private. Also, this reporting would have to conform to the Health Insurance Portability and Accountability Act's privacy regulations. Although the HIPAA privacy regulations are not finalized, they will require that patient information only be shared to the extent needed for the provision of medical services and the processing of medical claims. Written patient consent is required if medical information is provided.

Studies indicate that the major causes of health problems in adults are the result of life style choices made during the school age years. If school-based health centers can positively impact the number of children that choose unhealthy behavior, health in later life could be improved and health care costs could be reduced. Although improved health in later life is the goal of school-based health centers, there are no statistical evidence to-date that there is an effect on adult health. Experience indicates that school-based health centers reduce the use of emergency rooms. School-based health centers can also monitor chronic conditions in children. This monitoring can increase compliance with medical treatments that keep conditions under control, improving health and reducing health care costs.

Nationally, school-based health centers report that they are having trouble getting the financial support they need. Traditional funding for school-based health centers is from state, federal and private grants. These are limited and uncertain sources of future funding.[1] In order to survive financially, school-based health centers are looking to health insurers, HMOs and Medicaid to pay for services provided to the children covered by those plans. School-based health center advocates in Maine share the same concerns. School-based health centers in Maine report that the majority of their funding comes from sponsoring organizations (37%), school funding (19%) and grants (18%). Reimbursements from Medicaid and insurance represent 10% of current funding with local funds and student fees making up the remaining 16%. Since school-based health centers do not generally charge students for the services they provide, the proposed mandate would serve more as a funding mechanism for the centers rather than as traditional insurance.

Other states have attempted a number of techniques for coordinating school-based health centers with managed care. The process of integrating school-based health centers into a managed care paradigm is reportedly not a smooth one and no technique stands out as an

[1] JAMA, "25 Years of School-Based Health Centers", March 3, 1999, p. 782.

obvious best choice. A key concern is the coordination of care given by the school-based health centers and the student's primary care provider (PCP). In order to be reimbursed, health centers must implement administrative procedures for determining covered services and comply with billing procedures. Coordinated processes have to be developed so that HMO claim adjudication systems do not deny claims submitted by the school-based health center that have not been approved by the student's PCP. Although other states have found this challenging, it has not been impossible.

Also, insurance policies and HMO plans usually require the insured to pay a portion of the cost of services, typically $10 or $20 for an office visit, to put some of the financial responsibility for the cost of care on members and to discourage inappropriate utilization. If copayments are applied to services provided in a school-based health center, insured students might actually have to pay more than uninsured students. LD 600 does not address how this situation will be handled. Even if the clinics do not collect copayments from students, parents will be confused if they receive an Explanation of Benefits from the HMO implying that they now have to pay for a portion of the services that they thought were free or covered by their current annual payment for the school-based health center.

Based on the current number of centers, MMC estimates maximum premium increases of 0.4% for managed care plans and less than 0.2% for non-managed care plans. Cigna estimates cost increases of less than 0.5% and Anthem estimates increases of 0.1% - 0.2% for all plans. Aetna estimates a 20% increase in the portion of the premium allocated for children for all plans. United Healthcare Insurance Company estimated an increase to premiums for a typical group of less than 0.25%. Harvard Pilgrim and MEGA Life and Health Insurance Company did not respond to Bureau inquiries in time to be included in this report.

Self-funded health plans would not be required to comply with LD 600 and therefore would not experience an increase in costs.

II. Background

The Joint Standing Committee on Banking and Insurance of the 120th Maine Legislature directed the Bureau of Insurance to review LD 600, an Act to Implement the Recommendations of the Joint Select Committee on School-based Health Care. The review was conducted using the requirements stipulated under 24-A M.R.S.A., §2752 as amended by Public Law 2001, Chapter 28. This review was a collaborative effort of MMC Enterprise Risk Consulting, Inc. (MMC), a global professional services firm and the Maine Bureau of Insurance (the Bureau).

LD 600 would amend sections of Maine Law pertaining to Medicaid, individual health plans, group health plans and HMOs. This study focuses only on the provisions in the bill mandating that health carriers cover services provided in school-based health centers. These provisions would require:

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The bill contains the following additional requirements, which are beyond the scope of this report.

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develop standards and guidelines for school-based health centers and a certification process for school-based health centers. The advisory group would be required to submit its report and any necessary implementing legislation to the Joint Standing Committee on Health and Human Services.

Current insurance law does not require coverage of services provided by school-based health centers. However, fee-for-service plans can and sometimes do reimburse school-based health centers. In some circumstances some managed care plans also reimburse school-based health centers. This bill as written does not require the centers to participate but during the public hearing, proponents indicated that they would be willing to meet participating provider requirement.

The services provided by school-based health centers are more extensive than those typically provided by a school nurse. Services may include preventative health care visits, chronic condition monitoring and mental health services. Also, the types of providers found in school-based health centers include physicians and mental health professionals. School-based health centers began in two cities -- St. Paul, Minnesota and Dallas, Texas -- in the early 1970s. Nationally, centers grew to 50 by the early 1980's and reached 1,157 during the school year 1997/98. In spring 2000, it is estimated that more than 1,300 centers are providing care in schools across the country.[2] Currently, school-based health centers are located in 45 states and the District of Columbia. High schools and middle schools house more than half of the school-based health centers and elementary schools account for a third. The large majority of the centers are located in poor urban and rural areas, where primary health care, psychological services, and preventive care are scarce and children are likely to be uninsured or underinsured.[3]

In Maine, the first school-based health centers opened in 1987. Currently there are 26 school-based health centers in Maine, six of which opened in the fall of 2001. A recent survey of the 20 school-based health centers established in Maine prior to 2001 conducted by the School-based Health Council found that, of the 15 schools responding, 13% were elementary schools, 7% were middle schools, 66% were high schools, and 14% were a mixture of high school and lower grades. More than one half (53%) of the centers are open 25 hours or more a week and 20% have some services available in the summer.

[2] *School-Based Health Centers – Background*, The Center for Health and Health Care In Schools, www.healthinschools.org.
[3] "Tests That Count," *American School Board Journal*, January 2000.

Eight of the 15 schools had behavioral health staff with an average of 17.2 hours of behavioral health services a week. The 11 schools providing information on the types of services provided reported that, on average, of students visiting the center:

- 33% had a preventive health visit,
- 38% received health counseling,
- 59% were screened for health risk behaviors,
- 9% received reproductive health care,
- 8% were seen for chronic physical health conditions, and
- 4% were seen for chronic mental health conditions.

Chronic physical health conditions included asthma, obesity, diabetes, allergies and ADHD (Attention-Deficit/Hyperactivity Disorder). Chronic mental health conditions included depression, anxiety, substance abuse, and adolescent adjustment disorder.

The American Academy of Pediatrics has indicated that a school health program has seven major goals: [4]

1. To assure access to primary health care;
2. To provide a system for dealing with crisis medical situations;
3. To provide mandated screening and immunization monitoring;
4. To provide systems for identification and solution of students' health and educational problems;
5. To provide comprehensive and appropriate health education;
6. To provide a healthful and safe school environment that facilitates learning; and
7. To provide a system to evaluate the effectiveness of the school health program.

Funding for school-based health centers has traditionally been a patchwork of federal, state, local, and private funding sources. Shrinking funding is creating "a nearly insuperable barrier to the centers' long-term expansion and growth."[5]

In Maine, the fifteen school-based health centers responding to a recent survey indicated that the largest share of their funding (37%) came from sponsoring organizations. Sponsoring

[4] "Tests that Count." *American School Board Journal,* January 2000.
[5] Ibid.

organizations include hospitals, medical centers, or associated family or pediatric practice, Federally Qualified or Rural Health Centers, public health agencies (e.g., Portland Public Health Division) and associated schools. Other funding included school (19%), grants (18%), other local funds (13%), reimbursements from insurers and health plans (10%) and student fees (3%). Student fees, when applied, are in the form of an annual fee (averaging $35) or a per visit fee (averaging $15). Eleven centers charged Medicaid, including Cubcare, while eight charged private health insurers. The three that charged Medicaid but not private insurance were sponsored by the Portland Public Health Division, which is not recognized as a provider by private health insurers. School-based health centers had problems receiving reimbursement from managed care plans without a PCP referral.

III. Social Impact

A. Social Impact of Mandating the Benefit

1. The extent to which the treatment or service is utilized by a significant portion of the population.

In a recent survey of Maine school-based health centers conducted by the School-based Health Council, respondents reported that between 8% and 100% of their students were enrolled (with an average of 39% of the student body enrolled) in the center. On average 65% of the enrolled students used the health center, resulting in an average of 25% (65% of 39%) of the students in these schools using the health center. Schools in which the 15 responding centers were located had an average of 877 students. Assuming the other 11 schools in Maine that have health centers also average 877 students, approximately 22,800 or 8.6% of the students in Maine currently have access to school-based health centers. Based on a 25% utilization rate, this would mean that approximately 5,700 students or 2.15% of the students in Maine currently utilize these centers.

2. The extent to which the service or treatment is available to the population.

In Maine, the first school-based health centers opened in 1987. By 2000, 13 of Maine's 285 school districts had one or more school-based health center. The total number of centers was 20. Six more opened in the fall of 2001. School-based health centers are distributed throughout Maine in both rural and urban areas.

Maine school-based health centers as of December 2000

Boothbay
Boothbay Region High School

Portland
Deering High School
Jack Elementary School
King Middle School
Portland High School
Reiche Community School
West Elementary School

Auburn
Edward Little High School

China
Erskine Academy

Dover-Foxcroft
Foxcroft Academy
Se Do Mo Cha Middle School

Harmony
Harmony Elementary School

Leeds
Leavitt High School

Lewiston
Lewiston High School
Lewiston Middle School

Newcastle
Lincoln Academy

Lubec
Lubec Consolidated Schools

Readfield
Maranacook Community School

Berwick
Noble High School

South Paris
Oxford Hills Comprehensive High School

3. *The extent to which insurance coverage for this treatment is already available.*

If claims are submitted by sponsoring hospitals and clinics of the centers to fee-for-service or point-of-service plans, they are often covered. However, in some situations, insurance and Medicaid may not cover services provided at school-based health centers even if those services would be covered if provided elsewhere, such as in an emergency room or physician's office. For example, an HMO will not reimburse services if a school-based health center is not a participating provider with the HMO, or if a referral is not obtained from the primary care provider prior to the provision of service at the health center. The Portland Public Health Division is not recognized as a provider by private insurance and is therefore not reimbursed by commercial plans, although Medicaid does reimburse it.

4. *If coverage is not generally available, the extent to which the lack of coverage results in a person being unable to obtain the necessary health care treatment.*

School-based health center services are typically provided free or at a minimal cost to the students. In addition, the services provided in the 26 school-based health centers are available to Maine children in a variety of other settings, including emergency rooms, medical clinics, and physician offices. Private insurance is currently available for many of these services when rendered in these other settings. Some services such as mental health services may be optional insurance benefits or have policy limits on coverage.

Services available through school can provide easier access to health care than alternative settings. Students have transportation to their schools and do not have to depend on parents who may work during the day or may not have transportation available to them.

5. *If coverage is not generally available, the extent to which the lack of coverage involves unreasonable financial hardship.*

School-based health center services are typically free or provided at minimal cost to the students.

6. *The level of public demand and the level of demand from providers for this treatment or service.*

Proponents for reimbursement of school-based health centers includes the Maine Chapter of the National Assembly on School-Based Health Care, City of Portland's Health & Human Services Department, Public Health Division, League of Women Voters of Maine, and Maine Children's Alliance. One parent and one teacher from schools that have school-based health centers also testified in favor of LD 600.

7. *The level of public demand and the level of demand from the providers for individual or group coverage of this treatment.*

Based on testimony provided to the Joint Committee on Banking and Insurance,

there is demand for legislation from organizations that lobby for or support school-based health centers, students, parents, children's advocacy groups and educators. The National Assembly on School-based Health Care, the League of Woman Voters of Maine, and The Children's Alliance have submitted written testimony in favor of this type of legislation.

In the November 1, 2000 report of the Commission on Child Abuse, the commission voted to support school based health centers as an important frontline prevention of child abuse. The commission stated their endorsement of the centers that exist and encourage the centers' expansion.

Demand for reimbursement for school-based health centers is being driven by a concern that current funding will be reduced and that centers will have to close without other sources of revenue. Nationally school-based health centers report that they are having trouble getting the financial support they need. Traditional funding for school-based health centers comes from state, federal and private grants. These are limited and uncertain sources of funding. In order to survive financially, school-based health centers are looking to health insurers, HMOs and Medicaid to pay for services provided to the children covered by those plans.

Comments at a national meeting of representatives from all aspects of this issue included:[6]

> "Some advocates worry that, out of financial necessity, systems are clamping down on uncompensated care and sliding scale fee structures are increasingly commonplace – a practice that some worry may decrease access for low-income populations."

[6] National Assembly on School-Based Health Care, Determining A Policy Agenda to Sustain School-Based Health Centers: NASBHC Assesses the Health Care Safety Net Environment – June 2000.

"… mission and good intentions go out the window when the financial bottom line is affected."

"Without indigent care subsidies and adequate Medicaid reimbursement, community health representatives admitted that keeping comprehensive centers open was going to be a challenge."

8. *The level of interest in and the extent to which collective bargaining organizations are negotiating privately for the inclusion of this coverage by group plans.*

No information is available.

9. *The likelihood of meeting a consumer need as evidenced by the experience in other states.*

No other states have passed laws mandating insurance reimbursement for school-based health centers. Experience in states is still emerging as legislation is passed; however, the focus of other states' efforts and studies has been in the area of Medicaid reimbursement and organizational issues rather than insurance reimbursement.

10. *The relevant findings of the state health planning agency or the appropriate health system agency relating to the social impact of the mandated benefit.*

An analysis by the Bureau of Medical Services, provided by Dr. Tim Clifford, of the pilot project at the Maranacook school health center compared Medicaid data for the center to state-wide Medicaid medical costs of adolescents age 13-18. While the numbers are small, it suggests a cost savings to Medicaid for those individuals using the center for two out of three years.

11. *Alternatives to meeting the identified need.*

State grants could be increased to support school-based health centers, although this is not likely at a time when the state is experiencing a budget deficit. Federal or private grants may be available, although there is indication that these grants are becoming harder to find. United Healthcare Insurance Company suggested only mandating coverage of acute conditions without a referral and excluding counseling, health education and physical or occupational therapy entirely as being mandated for coverage. LD 600 does not mandate coverage of any service not already covered by the individual's plan, but there is a concern that the public may be confused as to what is covered. A pilot project could be developed between the centers and managed care plans to find workable arrangements and study results.

12. *Whether the benefit is a medical or a broader social need and whether it is inconsistent with the role of insurance and the concept of managed care.*

Proponents across the country feel that school-based health centers meet a social need beyond the medical care that they provide. School-based health centers have a mission beyond medical treatment that extends to health education and reaching out to youth. This out-reach is seen as a way to open communication among educators, physicians and families, which results in improved medical and emotional support for students.

The requirements of LD 600 are not inconsistent with the role of insurance to the extent that the services would be reimbursed if they were provided in another setting. The issue with school-based health centers becomes complicated because often there is no charge for services and insurance policies generally don't pay for services for which there would be no charge to the patient in the absence of insurance. In this respect, the mandate would serve more as a funding mechanism for school-based health centers than as traditional insurance. School-based health centers do not charge for services because expenses are now being covered by block grants, etc. If traditional school-based health center funding becomes insufficient, the centers will have to charge for services or close.

Although LD 600 only requires reimbursement for services currently covered by

insurers or Medicaid, one insurer, United Healthcare Insurance Company, is concerned that the requirement will be expanded to cover services traditionally considered part of education such as testing, health education, counseling and physical or occupational therapy.

LD 600 may not be compatible with the concept of managed care. Other states have attempted a number of methods to coordinate school-based health centers with managed care. For example, Connecticut, Massachusetts, Delaware, and New York required Medicaid Risk plans to contract with school-based health centers in their State.[7] The process of integrating school-based health centers into a managed care paradigm is reportedly not a smooth one and no technique stands out as an obvious best choice. In New York City, for example, integrating school-based health centers with managed care required the negotiation of more than 2,000 contracts. Even when contracting with school-based health centers, many plans fail to recognize nurse practitioners as health care providers and refuse to reimburse for group counseling and preventive services. Others require centers to maintain coverage 24 hours a day, seven days a week to be eligible for reimbursement.[8]

Managed care plans currently offer medical and mental health benefits, which are subject to management by primary care providers (PCPs). Managed care plans typically contract with select providers, who are responsible for overseeing and coordinating the care given to patients. Although more convenient during the school year, school-based health centers are usually open only on school days and during the school year. This makes it difficult to provide care management or continuity of treatment for conditions that need attention after hours, on weekends, or during school breaks. LD 600 would require that documentation of the treatment be provided to PCPs so that managed care plans can be aware of the treatment provided to their members.

Managed care plans have standards for participating providers. These standards include credentialing criteria based on NCQA standards and Maine law.

[7] School-Based Health Centers, *School-Based Health Centers and Managed Care: Seven School-Based Health Center Programs Forge New Relationships,* April 1996.
[8] "Tests That Count," *American School Board Journal*, January 2000.

Managed care plans also have guidelines that their in-network physicians have to understand and follow, such as drug formularies, conditions governing referral to a specialist and the appropriate number of visits for specific conditions. The school-based health centers would have to meet the same standards and follow the same guidelines in order to be participating providers and to receive reimbursement.

LD 600 would only require reimbursement for services covered by the benefit plan. School-based health centers and HMOs would need to have administrative procedures for determining covered services and coordinating billing processes. For example, unless systems or procedures are changed, claims from school-based health centers will not have a referral or pre-authorization on file from a PCP, and HMO claims payment systems would not recognize their claims. This complicates billing procedures for the school-based health centers since they would have to communicate to the HMO that referral and pre-authorization rules would not apply to services provided at the school-based health centers. The reimbursement from HMOs would have to be sufficient to cover any administrative activities needed to bill for services.

The bill does not require the center to be a participating provider for reimbursement but the proponents indicated at the public hearing that the sponsor would be willing to consider adding that requirement. Therefore, if LD 600 were revised in this manner, school-based health centers would not be recognized as participating providers unless they are under contract with the HMO. If the bill were amended in this manner, it would be necessary to address how much discretion, if any, HMOs would have in deciding whether to contract with a school-based health center.

Even in point-of-service plans where out-of-network services are covered, the amount reimbursed by the HMO is reduced and the amount the patient is responsible for is increased when services are obtained out of network. This will mean that parents will receive an explanation of benefits (EOB) which shows that they are responsible for a percentage of the cost. LD 600 does not address how this situation will be handled. Even if the clinics do not collect coinsurance from students, parents will be confused if the EOBs imply that they now have to pay for a portion of the school-based health centers services that they thought

were free or covered by their current annual payment.

LD 600 would permit copayments and deductibles. However, it is unknown how or if copayments would be collected by school-based health centers. Insurers use copayments to put some of the financial responsibility for the cost of care on members and to discourage inappropriate utilization. Since most school-based health centers do not charge students for the services provided or charge an annual fee, would they now charge a copayment to students that have insurance coverage, while not charging an uninsured student? The centers prefer not to have copayments because this restricts the access to services that they provide. With coverage changing frequently as parents change jobs or enroll in alternative plans during open enrollment, will the school-based health centers be able to track which students are insured and by which carrier? Students are rarely a good source for this information and typically do not carry insurance cards.

It would also be confusing when services are delivered to a student covered under a self-insured plan for which reimbursement of school-based health centers would not be required under LD 600. For example, an insurance card may indicate CIGNA as the carrier, when the plan is actually self-insured and CIGNA is only administering the benefits. It is not easy to distinguish between this situation and a fully insured plan subject to LD 600.

Managed care plans that capitate their PCPs are becoming rare in Maine, but when PCPs are capitated, HMOs contend that they already pay once for services to be provided to their members and that paying for school-based health centers services would force them to pay twice. Even when managed care plans contract with school-based health centers, rarely do the providers at the centers act as PCPs.

13. *The impact of any social stigma attached to the benefit upon the market.*

We know of no social stigma attached to using school-based health centers. Some services, such as mental health visits, may have some social stigma, but students have some added privacy protections at school-based centers that many

students use frequently without any indication of what services are being provided. Because of these privacy protections, there may be more willingness for students to use the services of school-based health centers when students do not have to have their parents drive them to appointments. Parents may need to give permission for their children to use the centers at the beginning of the school year, but they do not have to approve specific visits.

The requirement of LD 600 to report services to PCPs may inhibit some students from using services that they would prefer to keep private. Also, this reporting would have to conform to the Health Insurance Portability and Accountability Act's privacy regulations. Although the HIPAA privacy regulations are not finalized, they will require that patient information only be shared to the extent needed for the provision of medical services and the processing of medical claims. Written patient consent, or parental consent, is required if medical information is provided.

14. The impact of this benefit upon the other benefits currently offered.

It is reported that the major causes of health problems in adults come from life style choices made during the school age years.[9] If school-based health centers can help reduce the number of children that choose unhealthy behavior, health in later life may be improved and health care costs may be reduced. One physician is quoted as saying, "Obesity as an adult starts in childhood. Most smokers tried their first cigarette when they were 12 or 13 years old. The only way to get folks to stop drinking too much, eating too much, smoking too much and working too hard is to go back to this age group."[10] Although the logic of early intervention is compelling, there are no statistical studies showing that school based care reduces unhealthy behavior or improves health status.

School-based health centers can also monitor chronic conditions in children. This monitoring can increase compliance with medical treatments that keep conditions under control, improving health and potentially reducing health care

[9] Investing in Clinical Preventative Health Services for Adolescents.
[10] "Health Care Rare In School Despite Success Stories, School Health Clinics Are Having Trouble Getting Funded," Bruce Buchanan, Greensboro News & Record.

costs.

15. *The impact of the benefit as it relates to employers shifting to self-insurance and the extent to which the benefit is currently being offered by employers with self-insured plans.*

It is not anticipated that paying for services at school-based health centers alone will impact premiums sufficiently to cause employers to shift to self-insurance. Self-insured plans do not currently cover services provided by school-based health centers. However, the cumulative impact of mandated benefits must be considered and the more mandates, the higher likelihood that employers will consider self-insurance.

State legislation that imposes benefit mandates will heighten an employer's concern with regard to future costs and make self-insurance a more attractive alternative. The 1998 Mercer/Foster Higgins National Survey of Employer-sponsored Health Plans indicates that 36% percent of the large employers (500 or more employees) in the Northeast self-insure health plans.

16. *The impact of making the benefit applicable to the state employee health insurance program.*

Anthem estimated that LD 600 would increase the cost of the State Employee Health Insurance Plan by approximately 0.1% - 0.2%. This estimate is within a reasonable proximity of MMC's estimated maximum premium increment of up

to 0.4% per year for managed care plans and less than 0.2% premium increases for non-managed care plans or point-of-service plans, assuming the current number of centers and existing utilization.

IV. Financial Impact

B. Financial Impact of Mandating Benefits.

1. The extent to which the proposed insurance coverage would increase or decrease the cost of the service or treatment over the next five years.

School-based health center services are typically provided free or at a minimal cost to the students and are not always reimbursed by insurance carriers, HMOs or Medicaid. Therefore the cost to the payer of the services at school-based health centers would increase to the usual fee charged in other settings.

2. The extent to which the proposed coverage might increase the appropriate or inappropriate use of the treatment or service over the next five years.

It is not anticipated that coverage by insurers would change the use of the 26 school-based health centers that exist today. It would conceivably change only the funding source, not utilization.

Insurance coverage of services could encourage the development of other school-based health centers. If more school-based health centers were formed, it is anticipated that students would have better access to appropriate services and would seek treatment before it becomes necessary to use an emergency room. Treating conditions at an earlier onset would reduce the use of emergency rooms for inappropriate conditions. A cost-benefit analysis done in San Francisco showed savings from early detection of diseases as well as from the use of school-based health centers rather than emergency rooms.[11]

If school-based health centers cannot survive, inappropriate emergency room use may increase to replace services currently provided in the centers.

3. The extent to which the mandated treatment or service might serve as an alternative for more expensive or less expensive treatment or service.
Proponents argue that the cost savings from reduced emergency room visits and

[11] The National Adolescent Health Information Center University of California, San Francisco; "Investing in Preventive Health Services for Adolescents."

the early and effective treatment of conditions will more than offset any additional utilization of school-based health centers. As stated in the answer to the previous question, if there is growth in the number of school-based health centers, they may replace more expensive emergency room visits.

4. *The methods which will be instituted to manage the utilization and costs of the proposed mandate.*

Managed care plans and school-based health centers will have to work together to develop a mechanism to insure the appropriate level of care. As stated earlier, other states have found this challenging, but not impossible.

A project in San Diego County California is dealing with utilization management. Schools and a number of HMOs are working on mechanisms to identify students' primary care providers (PCPs). The coordination between school-based health centers and HMOs allows the two to work together to control utilization, access and appropriate place of service. For example, TB skin tests administered by PCPs can be read at school. Also, coordination reduces unnecessary referrals from schools to health plans for attention deficits and unnecessary referrals from plans to schools for special education work-ups.[12]

5. *The extent to which insurance coverage may affect the number and types of providers over the next five years.*

This legislation could increase the number of school-based health centers. To the extent that school-based health centers have not been established because of financial considerations, the reimbursement from health plans combined with other sources may provide sufficient funding. It is not possible to predict if the reimbursements required by LD 600 would be sufficient to encourage a growth in school-based health centers or even sufficient to replace funding lost if current grants are no longer available.

6. *The extent to which the insurance coverage of the health care service or provider may be reasonably expected to increase or decrease the insurance premium or administrative expenses of policyholders.*

[12] School Health Newsletter, Winter 1997.

MMC estimates maximum premium increases for managed care plans of 0.4% depending on the amount of school-based health center services currently being reimbursed. Since non-managed care plans are more likely to currently reimburse services in school-based health centers, MMC estimates that premium increases would be less than 0.2%. Details of MMC's assumptions can be found in Appendix D.

Cigna estimates cost increases of less than 0.5% and Anthem estimates increases of 0.1% - 0.2% for all plans. Aetna estimates a 20% increase in the portion of premium allocated for a child for all plans. United Healthcare Insurance Company estimated an increase in premiums for a typical group of less than 0.25%. Harvard Pilgrim and MEGA Life and Health Insurance Company did not respond to Bureau inquiries in time to be included in this report.

Self-funded plans would not be required to comply with LD 600 and therefore would not experience an increase in costs.

Health plans will also incur administrative costs associated with communicating and implementing the reimbursement of school-based health centers required by LD 600, which could not be quantified at this time.

7. *The impact of indirect costs, which are costs other than premiums and administrative costs, on the question of the cost and benefits of coverage.*

There would be no additional increase in cost beyond premiums and administrative costs. Cost to school-based health centers for billing would be considered administrative costs.

8. *The impact on the total cost of health care, including potential benefits and savings to insurers and employers because the proposed mandated treatment or service prevents disease or illness or leads to the early detection and treatment of disease or illness that is less costly than treatment or service for later stages of a disease or illness.*

There have been studies that indicate that the major causes of health problems in adults come from life style choices made during the school-age years. If school-based health centers can positively impact the number of children that choose

unhealthy behaviors, health in later life could be improved and health care costs could be reduced. Any such savings would be long-term and may not have any immediate effect in offsetting the cost of the mandated benefit.

Experience indicates that school-based health centers reduce the use of emergency rooms. School-based health centers can also monitor chronic conditions in children. This monitoring can increase compliance with medical treatments that keep conditions under control, improving health and reducing health care costs.

9. *The effects of mandating the benefit on the cost of health care, particularly the premium and administrative expenses and indirect costs, to employers and employees, including the financial impact on small employers, medium-sized employers and large employers.*

The cost to employers should not vary by size. There is no reason to believe that any change in cost would affect small employers differently than medium-sized or large employers. MMC estimates that there would be a maximum premium increase of 0.4% annually for employers with managed care plans and less than 0.2% increase for non-managed care plans. Since small employers tend to be more sensitive to premium increases, this increase is more likely to result in small employers shifting costs to employees, reducing benefits or dropping coverage.

10. *The effect of the proposed mandate on cost-shifting between private and public payors of health care coverage and on the overall cost of the health care delivery system in this State.*

Clinics are currently funded through public money. Insurance reimbursements would not reduce the need for public funds by a significant amount because the populations served tend to be Medicaid and uninsured.

V. Medical Efficacy

C. The Medical Efficacy of Mandating the Benefit.

1. The contribution of the benefit to the quality of patient care and the health status of the population, including any research demonstrating the medical efficacy of the treatment or service compared to the alternative of not providing the treatment or service.

Research concerning the effect on health due to the availability of school-based health centers is only anecdotal at this time. As one doctor said, students "do not carry appointment books. Health services need to be where students can trip over them."

Centers increase access to care for young people who may not have access to regular providers and who have not seen a physician recently. The centers provide a range of physical and mental health services, with care for psycho-social problems which is an increasingly important service component.[13]

There is a general consensus among physicians that adolescents are underserved when it comes to health care. It is believed that they do not receive adequate preventative services, health screening and health guidance.[14]

The health status of adolescents and young adults has been the subject of growing concern due to the increased health problems caused by unhealthy behaviors. There are now a number of national efforts to study the special health and social needs of adolescents. Some professionals believe that school-based health centers may provide a critical link between adolescents and needed services.[15] At school-based health centers physicians often spend more time with

[13] *School-Based Health Centers – Background*, The Center for Health and Health Care In Schools, www.healthinschools.org.
[14] Irwin, C. E., Brindis, C., Holt, K. A., and Langlykke, K. (Eds.). (1994). *Health Care Reform: Opportunities for Improving Adolescent Health*. Arlington, VA: National Center for Education in Maternal and Child Health.
[15] Improving Adolescent Health: An Analysis and Synthesis of Health Policy Recommendations. National

students than doctors have available in more traditional environments. In a school-based setting it is more common for doctors to spend time discussing healthy lifestyles and personal issues. Doctors also have better access to information about patients, such as classroom performance and social behavior in the school setting.

Grimsley Clinic in North Carolina reports that some students with ailments such as asthma and diabetes receive daily treatment. Having a clinic at school means these students do not have to miss class or find a ride to the doctor's office. Some students with chronic health problems have even transferred to the school so they can have access to daily medical care.[16]

2. *If the legislation seeks to mandate coverage of an additional class of practitioners relative to those already covered.*

   a. *The results of any professionally acceptable research demonstrating medical results achieved by the additional practitioners relative to those already covered.*

      We were unable to find studies comparing medical outcomes from care provided by school-based health centers practitioners to those in other settings. Anecdotal information points to better adherence to medical treatments for chronic conditions and positive impacts on lifestyle choices.

   b. *The methods of the appropriate professional organization that assure clinical proficiency.*

      The Bureau of Health, the State agency that administers grants to school-based health centers, is developing "Maine School-Based Health Centers Standards." These standards will only provide guidance and are not intended to supercede Maine Law.

Adolescent Health Information Center Division of Adolescent Medicine, Department of Pediatrics and Institute for Health Policy Studies School of Medicine University of California, San Francisco.

[16] "Health Care Rare In School Despite Success Stories, School Health Clinics Are Having Trouble Getting Funded," Bruce Buchanan, Greensboro News & Record.

No one organization oversees the clinical proficiency of school-based health centers. Hospital, clinic and health plan based centers are responsible to their sponsors for their clinical proficiency.

In Portland, the City of Portland's Health & Human Services Department, Public Health Division operates the City's six school-based health centers.

VI. Balancing the Effects

D. The Effects of Balancing the Social, Economic, and Medical Efficacy Considerations.

1. The extent to which the need for coverage outweighs the cost of mandating the benefit for all policyholders.

National Statistics indicate that every four hours a child commits suicide. Approximately 36 children are victims of gun violence each day. Every 30 seconds a child starts smoking, and every 60 seconds a child is born to a teenage mother.[17] Physicians and educators believe that having support services in the schools will result in improved care for emotional problems and better life style choices. Most school-based health centers provide health counseling and behavioral health counseling.[18]

Proponents point out that children with medical or emotional problems cannot focus on their studies. Having medical and mental health services accessible reduces these problems and allows for improved learning.

Access to care is improved by school-based health centers. Taking children to the doctor can be a problem for parents who work during the day, who have other children to care for, or who do not have transportation available. Schools can help by making care services available to students.[19]

National proponents of school-based health centers list the advantages of sponsoring a school-based health centers as:[20]

- One of the best strategies for improving both public and personal health

[17] Health, Mental Health, and Safety in Schools Newsletter, Issue 1, "Joint Chairs Report."
[18] 25 Years of School-Based Health Centers, M. J. Friedrich, JAMA, March 3, 1999—Vol 281, No. 9 781.
[19] *School Health Newsletter,* Winter 1997.
[20] National Assembly on School-Based Health Care, Determining A Policy Agenda to Sustain School-Based Health Centers: NASBHC Assesses the Health Care Safety Net Environment – June 2000.

outcomes and indicators;

- An important gateway to mental health and substance abuse services;
- A unique service niche for a hard-to-reach adolescent population;
- An opportunity to keep children and youth in school;
- An effective agent for getting school-age youth enrolled in public insurance;
- A vital link between the school and the community; and
- A cost-effective and convenient strategy for parents and employers.

The increase in access would also result in increased utilization and therefore costs. Offsetting the increase in office visits may be a decrease in costly emergency room visits. School-based health centers can also monitor chronic conditions in children. This monitoring can increase compliance with medical treatments that keep conditions under control, improving health and reducing health care costs.

Opponents are concerned that there will be pressure for services to be eligible for reimbursement that are not currently covered by health plans, but available in school-based health centers. There is also a concern that more school-based health centers will be established and that utilization will increase inappropriately due to the accessibility of services. If utilization increased without a drop in emergency room usage, costs would increase.

2. *The extent to which the problem of coverage can be resolved by mandating the availability of coverage as an option for policyholders.*

Since school-based health center services are already available to students for no charge or a very reduced charge, there would be little incentive for policyholders to pay for this benefit if it were an option.

3. *The cumulative impact of mandating this benefit in combination with existing mandates on costs and availability of coverage.*

It is not possible to precisely measure the impact of mandated benefits. However, it is possible to estimate an outside limit, the maximum possible increase in health insurance premiums resulting from mandates. Because various mandates apply to different categories of coverage, this maximum likewise varies. The Bureau's estimates of the maximum premium increases due to

existing mandates and the proposed mandate are displayed in Table C.

TABLE C – MAXIMUM PREMIUM INCREASES **Current Mandates**			
	Group (more than 20 employees)	**Group (20 or fewer employees)**	**Individuals**
Fee-for-Service Plans	8.44 %	4.34 %	4.33 %
Managed Care Plans	7.36 %	4.46 %	4.36 %
LD 600			
Fee-for-Service Plans	0.2 %	0.2 %	0.2 %
Managed Care Plans	0.4 %	0.4 %	0.4 %
Cumulative Impact			
Fee-for-Service Plans	8.64 %	4.54 %	4.53 %
Managed Care Plans	7.76 %	4.86 %	4.76 %

These estimates are based on the estimated portion of claim costs that mandated benefits represent, as detailed in Appendix B. The true cost impact may be less than this for two reasons:

1. Some of these services would likely be provided and reimbursed even in the absence of a mandate.

2. It has been asserted (and some studies confirm) that covering certain services or providers will reduce claims in other areas. For instance, covering mental health and substance abuse may reduce claims for physical conditions. Covering social workers may reduce claims for more expensive providers such as psychiatrists and psychologists. Covering chiropractic services may reduce claims for back surgery. Covering screening mammograms may reduce claims for breast cancer treatment.

While both of these factors reduce the cost impact of the mandates, we are not able to estimate the extent of the reduction at this time. While some studies have estimated much higher costs for mandated benefits, these studies were not based on the specific mandates applicable in Maine and therefore are not relevant.

There is no direct indication that mandated benefits have impacted the availability of health insurance in Maine.

VII. Appendices

Appendix A: Letter from the Committee on Banking and Insurance with Proposed Legislative Amendments

Appendix B: Cumulative Impact of Mandates

Following are the estimated claim costs for the existing mandates without the reductions:

- ***Mental Health*** - The mandate applies only to groups of more than 20. The amount of claims paid has been tracked since 1984 and has historically been in the range of 3% to 4% of total group health claims. Mental health parity for listed conditions was effective 7/1/96. The percentage has been decreasing in recent years from a high of 4.16% in 1997 to the preliminary 2000 figure of 3.13%. For 2000, this broke down as 2.9% for HMOs and 3.7% for indemnity plans. We assume the same levels going forward.

- ***Substance Abuse*** - The mandate applies only to groups of more than 20 and does not apply to HMOs. The amount of claims paid has been tracked since 1984. Until 1991, it was in the range of 1% to 2% of total group health claims. This percentage has shown a downward trend beginning in 1989 and continuing through 1999 when it reached 0.38%. This is probably due to utilization review, which has sharply reduced the incidence of inpatient care. Inpatient claims decreased from about 90% of the total to about 55%. Preliminary 2000 results show a slight increase to 0.41%. We estimate the percentage to remain at about the 0.4% level.

- ***Chiropractic*** - The amount of claims paid has been tracked since 1986 and has been approximately 1% of total health claims each year. However, the trend has been increasing since 1994. The percentage has increased from 0.84% that year to 1.46% in 1999 and a preliminary value of 1.69% in 2000. Based on this trend, we estimate 1.8% going forward.

- ***Screening Mammography*** - The amount of claims paid has been tracked since 1992 and generally has been in the range of 0.2% to 0.3%. It increased to 0.31% in 1999 and preliminary 2000 results show 0.51% which may reflect increasing utilization of this service. We estimate 0.5% going forward.

- ***Dentists*** - This mandate requires coverage to the extent that the same services would be covered if performed by a physician. It does not apply to HMOs. A 1992 study done by Milliman and Robertson for the Mandated Benefits Advisory Commission estimated that these claims represent 0.5% of total health claims and that the actual impact on premiums is "slight." It is unlikely that this coverage would be excluded in the absence of a mandate. We include 0.1% as an estimate.

- ***Breast Reconstruction*** - At the time this mandate was being considered in 1995, Blue Cross estimated the cost at $0.20 per month per individual. We have no more recent estimate. We include 0.02% in our estimate of the maximum cumulative impact of mandates.

- ***Errors of Metabolism*** - At the time this mandate was being considered in 1995, Blue Cross estimated the cost at $0.10 per month per individual. We have no more recent estimate. We include 0.01% in our estimate.

- ***Diabetic Supplies*** - Our report on this mandate indicated that most of the 15 carriers surveyed said there would be no cost or an insignificant cost because they already provide coverage. One carrier said it would cost $.08 per month for an individual. Another said .5% of premium ($.50 per member per month) and a third said 2%. We include 0.2% in our estimate.

- ***Minimum Maternity Stay*** - Our report stated that Blue Cross did not believe there would be any cost for them. No other carriers stated that they required shorter stays than required by the bill. We therefore estimate no impact.

- ***Pap Smear Tests*** - No cost estimate is available. HMOs would typically cover these anyway. For indemnity plans, the relatively small cost of this test would not in itself satisfy the deductible, so there would be no cost unless other services were also received. We estimate a negligible impact of 0.01%.

- ***Annual GYN Exam Without Referral*** (managed care plans) - This only affects HMO plans and similar plans. No cost estimate is available. To the extent the primary care provider would, in absence of this law, have performed the exam personally rather than referring to an OB/GYN, the cost may be somewhat higher. We include 0.1%.

- ***Breast Cancer Length of Stay*** - Our report estimated a cost of 0.07% of premium.

- ***Off-label Use Prescription Drugs*** - The HMOs claimed to already cover off-label drugs, in which case there would be no additional cost. However, providers testified that claims have been denied on this basis. Our report does not resolve this conflict but states a "high-end cost estimate" of about $1 per member per month (0.6% of premium) if it is assumed there is currently no coverage for off-label drugs. We include half this amount, or 0.3%.

- ***Prostate Cancer*** - No increase in premiums should be expected for the HMOs that provide the screening benefits currently as part of their routine physical exam benefits. Our report estimated additional claims cost for indemnity plans would approximate $0.10 per member per month. With the inclusion of administrative expenses, we would expect a total cost of approximately $0.11 per member per month, or about 0.07% of total premiums.

- ***Nurse Practitioners and Certified Nurse Midwives*** - This law mandates coverage for nurse practitioners and certified nurse midwives and allows nurse practitioners to serve as primary care providers. This mandate is estimated to increase premium by 0.16%.

- ***Coverage of Contraceptives*** – Health plans that cover prescription drugs are required to cover contraceptives. This mandate is estimated to increase premium by 0.8%.

- ***Registered Nurse First Assistants*** – Health plans that cover surgical first assisting are mandated to cover registered nurse first assistants if an assisting physician would be covered. No material increase in premium is expected.

- ***Access to Clinical Trials*** – Our report estimated a cost of 0.46% of premium.

- ***Access to Prescription Drugs*** – This mandate only affects plans with closed formularies. Our report concluded that enrollment in such plans is minimal in Maine and therefore the mandate will have no material impact on premiums.

- ***Hospice Care*** – No cost estimate was made for this mandate because the Legislature waived the requirement for a study. Since carriers generally cover hospice care already, we assume no additional cost.

- ***Access to Eye Care*** – This mandate affects plans that use participating eye care professionals. Our report estimated a cost of 0.04% of premium.

- ***Dental Anesthesia*** – This mandate requires coverage for general anesthesia and associated facility charges for dental procedures in a hospital for certain enrollees for whom general anesthesia is medically necessary. Our report estimated a cost of 0.05% of premium.

These costs are summarized in the following table.

COST OF EXISTING MANDATED HEALTH INSURANCE BENEFITS

Year Enacted	Benefit	Type of Contract Affected	Est. Maximum Cost as % of Premium	
			Indemnity	HMO
1975	**Maternity** benefits provided to married women must also be provided to unmarried women.	All Contracts	0[21]	0[21]
1975	Must include benefits for **dentists'** services to the extent that the same services would be covered if performed by a physician.	All Contracts except HMOs	0.1%	--
1975	Family Coverage must cover any **children** born while coverage is in force from the moment of birth, including treatment of congenital defects.	All Contracts except HMOs	0[21]	--
1983	Benefits must be included for treatment of **alcoholism and drug dependency**.	Groups of more than 20 except HMOs	0.4%	--
1975 1983 1995	Benefits must be included for **Mental Health Services**, including psychologists and social workers.	Groups of more than 20	3.7%	2.9%
1986 1994 1995 1997	Benefits must be included for the services of **chiropractors** to the extent that the same services would be covered by a physician. Benefits must be included for therapeutic, adjustive and manipulative services. HMOs must allow limited self referred for chiropractic benefits.	All Contracts	1.8%	1.8%
1990 1997	Benefits must be made available for screening **mammography**.	All Contracts	0.5%	0.5%
1995	Must provide coverage for **reconstruction of both breasts** to produce symmetrical appearance according to patient and physician wishes.	All Contracts	0.02%	0.02%
1995	Must provide coverage for **metabolic formula** and up to $3,000 per year for prescribed modified low-protein food products.	All Contracts	0.01%	0.01%
1996	Benefits must be provided for **maternity (length of stay)** and newborn care, in accordance with "Guidelines for Perinatal Care."	All Contracts	0	0
1996	Benefits must be provided for medically necessary equipment and supplies used to treat **diabetes** and approved self-management and education training.	All Contracts	0.2%	0.2%
1996	Benefits must be provided for **screening Pap tests**.	Group, HMOs	.01%	0
1996	Benefits must be provided for **annual gynecological exam** without prior approval of primary care physician.	Group managed care	--	0.1%
1997	Benefits provided for **breast cancer treatment** for a medically appropriate period of time determined by the physician in consultation with the patient.	All Contracts	.07%	.07%
1998	Coverage required for **off-label use of prescription drugs** for treatment of cancer, HIV, or AIDS.	All Contracts	0.3%	0.3%
1998	Coverage required for **prostrate cancer screening**.	All Contracts	.07%	0
1999	Coverage of nurse **practitioners and nurse midwives** and allows nurse practitioners to serves as primary care providers	All Managed Care Contracts		0.16%
1999	Prescription drug must include **contraceptives**	All Contracts	0.8%	0.8%
1999	Coverage for **registered nurse first assistants**	All Contracts	0	0

[21] This has become a standard benefit that would be included regardless of the mandate.

2000	Access to **clinical trials**	All Contracts	0.46%	0.46%
2000	Access to **prescription drugs**	All Managed Care Contracts	0	0
2001	Coverage of **hospice care services** for terminally ill	All Contracts	0	0
2001	Access to **eye care**	Plans with participating eye care professionals	0	0.04%
2001	Coverage of **anesthesia** and facility charges for certain **dental** procedures	All Contracts	0.05%	0.05%
Total cost for groups larger than 20:			**8.44%**	**7.36%**
Total cost for groups of 20 or fewer:			**4.34%**	**4.46%**
Total cost for individual contracts:			**4.33%**	**4.36%**

Appendix C: References

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Appendix D: LD 600 Benefit Cost Estimates

LD - 600 SCHOOL BASED HEALTH CLINICS
EXPECTED INCREASE IN COST OF INSURANCE

Age Group	Member Distribution	Claims PMPM	Increase in Costs	Adjusted PMPM	Net Increase
<1	0.89%	452.35			
01-04	4.39%	71.06			
05-09	7.31%	47.01			
10-14	9.61%	54.04			
15-19	8.85%	88.61			
20-24	4.45%	92.94			
25-29	5.89%	141.76			
30-34	7.69%	152.57			
35-39	10.08%	150.64			
40-44	12.47%	166.80			
45-49	11.32%	195.60			
50-54	7.83%	236.94			
55-59	5.11%	288.06			
60-64	2.92%	367.18			
65+	1.20%	525.40			
Total Adult	68.96%	192.37	0.0%	192.37	
Total 0-4 Child	5.29%	135.37	0.0%	135.37	
Total 5-19 Child	25.76%	63.92	3.6%	66.25	
Total	100.00%	156.27		156.87	0.38%